Fairfax Skindeep Tattoo Removal Program Application--Part A

(1) Patient Name: _____ (Last) (First) (Middle or Initial)	(2) DOB: AGE:	(3) Sex	(4) SSN (if known)
(5) Address: _____ _____ City State	(6) Home Phone # ( ) _____ (Area code required)	(7) FAIRFAX COUNTY RESIDENT? Y N	
(9)Educational Program Name: Level:	(10) Employment/Vocational Training Name:	(11) Employment/Vocational Phone# ( ) _____ (Area code required)	

(12) Parents(s)/Guardian(s) Name	Relationship	Address	Phone #
(13) Family Physician Name:	N/A		

(14a) Part B of Application Completed? Completed? (circle) Y N (14b) Youth Participation Agreement Form Completed? (circle) Y N	(15a) 40 Hours Community Service completed? Y N (15b) Type and location of Community Service:	(16) Tattoo Location(s) (circle): face, neck, fingers, hands, forearms, other:	(17) Today's Date:
(18) 6 Months of Non-gang Association ? (circle) Y N	(19) Agencies Permitted to Exchange Information: CSB DFS FCPS HD JDRC ASPRS CBO		
(20) Information Exchange Permitted? (refer to the Consent to Exchange/Release Information Form for questions 20& 21) (circle) Y N		(21) Consent Expiration Date:	
(22) Referral Source:	(23) Case Manager name: Phone #	(24) Case Manager signature: _____	

Fairfax Skindeep Tattoo Removal Program Application--Part B

This section is to be completed and signed by the applicant.

1. Please explain why you would like to have your tattoo(s) removed.

_____ _____

First and Last Name of Applicant (please print) **Applicant Signature**

Fairfax Skindeep Tattoo Removal Program Application Instructions

The Fairfax Skindeep Tattoo Removal Program is a voluntary collaboration between Fairfax County youth, families, and/or care givers, public human services agencies, and Community-Based Organizations who will actively and creatively work to address the needs of at-risk youth and families at minimal cost to the taxpayers.

Visible tattoo removal is in recognition of and incentive for positive internal change over a 6 month period by youths through age 21 currently supervised by Fairfax County human services agencies or Community-Based Organizations. Each youth must actively demonstrate their willingness to leave gang life behind. Other requirements include:

- Attend 100% of education classes and pass with a "C" or better
- Seek active, remunerative employment if educational requirement has been satisfied
- Maintain 100% drug and alcohol sobriety during the period of program participation
- Demonstrate compliance with behavior contract and /or signed Rules of Probation
- Complete 40 hours of community services prior to tattoo removal

The Skindeep Tattoo Removal Interagency Committee will evaluate and prioritize applications. The American Society of Plastic and Reconstructive Surgeons will medically assess visible tattoos. Typical tattoo removal requires 4-6 months. Compensatory time is available to Fairfax County employees upon approval by their supervisors. Case managers/mentors are required to submit documentation and participate as follows:

1. Complete and submit Program Application Forms (Part A&B), Youth Participation Agreement, Exchange/Release Form, and Rosenberg Self-esteem Scale (RSE), most recent social history and service plan to the agency representative
2. Attend all program events including the interview, medical assessment, and tattoo removal
3. Arrange youth attendance, transportation, and foreign language translation
4. Ensure parent, guardian or care giver attendance at initial medical assessment
5. Timely cancellation at least 24 hours in advance is the sole responsibility of the case manager

Failure to comply with Program Requirements, Youth Participation Agreement, or Rules of Probation could result in suspension from the program. Reinstatement may be achieved by a demonstration of compliance with Program Requirements.

CASE FLOW CHECK LIST:

- ☐ 1. Case Manager submits **Application Form Part A & B, Youth Participation Agreement, Exchange/Release Form,** and **Rosenberg Self-Esteem Scale** to Agency Skindeep Representative.
- ☐ 2. Agency Representative collects and checks all forms for accuracy. The forms are then submitted to the Skindeep Committee for recommendation.
- ☐ 3. Committee reviews all applications and case histories.
- ☐ 4. Committee selects and recommends eligible youths to surgeons via the **Physician Notification Form**.
- ☐ 5. Surgeons review cases at an initial screening appointment and determine medical appropriateness of the recommended youths. Case manager arranges transportation, parent or guardian participation, and translation (if necessary).
- ☐ 6. If youth is approved for tattoo removal, he or she is scheduled for a subsequent tattoo removal appointment(s) (The **Laser Treatment Consent Form**, and **Request for Treatment Form** are completed at this time).
- ☐ 7. Case Manager completes and submits Follow-up Forms (**Exit Data Collection** and **Participant Survey**) to the Agency Representative.

Fairfax Skindeep Tattoo Removal Program
Youth Participation Agreement

I would like to participate voluntarily in the Skindeep Tattoo Removal Program.

I am _____years old. My date of birth is_____.

I, (print full name)_____, agree to disassociate myself from gang membership or affiliation with any gang members.

I was formerly a member/associate of_____.
(name of gang)

I promise not to join a gang if and when my tattoo is removed.

I consent to having the Skindeep Tattoo Removal Committee or their representative take photographs of the tattoo(s) that I am requesting to have removed.

I promise to enroll in and attend 100% of school, GED classes, or vocational training.

Name of school or educational program:_____.

I promise to be gainfully employed or to actively seek full-time employment if I have satisfied my educational requirements.

Name of employer:_____.

I promise to be drug and alcohol free during my participation in the Skindeep Tattoo Removal Program.

I promise to complete 40 hours of community service prior to tattoo removal.

I promise to provide my own transportation to all of the required appointments.

I promise to comply with all information requests for statistical record keeping purposes including a six-month follow-up survey.

I promise to sign consent or any other forms required for these services, including a “hold harmless” agreement for medical malpractice, civil liability and negligence.

_____ _____
YOUTH SIGNATURE DATE

_____ _____
WITNESS DATE

The Rosenberg Self-Esteem Scale (RSE)*

IDNUM:_____ DATE:____/____/____

Check one: ☐ Pre-test ☐ Post-test

About Myself

Instructions*:* Listed below are 10 statements. Please **circle** the response that best describes how you feel.

		Strongly disagree	Disagree	Agree	Strongly agree
1.	I feel that I'm a person of worth, at least on an equal basis with others	1	2	3	4
2.	I feel that I have a number of good qualities	1	2	3	4
3.	All in all, I am inclined to feel that I am a failure	1	2	3	4
4.	I am able to do things as well as most other people	1	2	3	4
5.	I feel I do not have much to be proud of	1	2	3	4
6.	I take a positive attitude toward myself	1	2	3	4
7.	On the whole, I am satisfied with myself	1	2	3	4
8.	I wish I could have more respect for myself	1	2	3	4
9.	I certainly feel useless at time	1	2	3	4
10.	At times I think I am no good at all	1	2	3	4

* Created by Dr. Manny Rosenberg

CONSENT TO EXCHANGE INFORMATION/RELEASE OF INFORMATION CONSENT

I understand that different agencies provide different services. Each agency must have specific information in order to provide services. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

_____

(Full Printed Name of Client)

_____/_____/_____ _____

(Clients birth date) *(Clients SSN - Optional)*

My relationship to the client is: ☐Self ☐Parent ☐Guardian

I want the following confidential information about the client to be exchanged:

☐	Assessment Information	☐	Medical Diagnosis	☐	Educational Records
☐	Financial Information	☐	Medical Health Diagnosis	☐	Psychiatric Records
☐	Medical Records	☐	Criminal Justice Records	☐	Due Process Files
☐	Psychological Records	☐	Social History	☐	Other_____

I want the: Fairfax Skindeep Tattoo Removal Program

And the following Fairfax Agencies to be able to exchange this information:

☐	Department of Family Services	☐	Fairfax County Public Schools	☐	Community Services Board
☐	Fairfax County Police	☐	Juvenile Court	☐	Community Based Organization
☐	Health Department	☐	American Society of Plastic and Reconstructive Surgeons		

Other Private Therapist, School, Hospital, or Service Provider:_____

In alcohol or drug cases the client must be the consenting party. In A.D.S.-Substance abuse cases - also be aware that such information is protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I want this information to be exchanged ONLY for Service Coordination and Treatment Planning and I want information to be shared: (check all that apply)

☐	Written Information	☐	In Meetings or By Phone	☐	Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until exit or completion of the program.

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information has been shared, and why, when, and with who it was shared. If I ask, each agency will show me this information.

I want the agencies to accept a copy of this form as a consent to share information.

Signature(s):_____

CONSENTING PERSON OR PERSONS **Client**

Written Names:_____ Date: ____/____/____

WITNESS (If Required):_____

(Signature) (Telephone)